

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

03758

CD

Reg. Dist. No.

95

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County CecilCity or town Rural Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Logan Nursing HomeHow long in hospital or institution? 18 hrs - 30 min.

## 3. (a) FULL NAME

Joseph Richard Barrett4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced S

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

April 15, 19486. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

13 hrs. 30 min.

## 9. Birthplace

Rising Sun Rural Cecil Md.

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Maurice Henry BarrettFATHER 12. Name West Nottingham, Md.13. Birthplace West Nottingham, Md.MOTHER 14. Maiden name Anna J. Hupp15. Birthplace West Phila. Pa.16. Informant Mrs. Maurice H. BarrettAddress Peach Bottom, Pa.17. Burial Date thereof April 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Harmony ChapelLocation Port Deposit, Md.18. Funeral Director Lee J. Patterson & SonAddress Perryville, Md.19. April 16, 1948 J. Washington  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNACounty ChessterCity or town Peach Bottom

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 16, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15, 1948 to April 16, 1948and that I last saw him alive on April 16, 1948Immediate cause of death Prematurity

DURATION

Due to Premature Labor; Child  
About 2 months pregnancy,  
Due to birth wt. 3 pounds.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Oxford, Pa.Date signed 4-16-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03759

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

96

## 1. PLACE OF DEATH:

County CecilCity or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hr. hours

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? About 1/2 hour

## 3. (a) FULL NAME

Sevis C. Blackburn4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Sena Blackburn7. Birth date of deceased (mo., day, yr.) Jan. 10. 18728. AGE: Years 76 Months 2 Days 24 If less than one day hrs. 00 min. 009. Birthplace Roxburyville, Md.

(Town, county, and state)

10. Usual occupation Retired

## 11. Industry or business

12. Name James A. Blackburn13. Birthplace Roxburyville, Md.14. Maiden name Marian Higge15. Birthplace Baltimore, Md.16. Informant Sevis Blackburn Jr.Address North East, Md.17. Burial Burial Date thereof April 7. 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory CoburyLocation near Perryville, Md.18. Funeral director J. E. LyonAddress Rising Sun, Md.

April 5 1948

(Date rec'd by registrar)

J. R. Frazer  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CecilCity or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4. 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 3 1948 to April 4, 1948and that I last saw h. in alive on April 4, 1948

Immediate cause of death

abdominal hemorrhage

DURATION

ruptured aneurysmabdominal cavity : Non-syphilitic

Due to

Other conditions Arterio sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medowman

M.D. or other

Address 202 E Main St Date signed 4/4/48

RECEIVED  
APR 7 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03760

490

## CERTIFICATE OF DEATH

Reg. Distr. No. 95

1. PLACE OF DEATH: *Cecil Co.*  
 County *Rising Sun, Md.*  
 City or town. (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *36*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Cecil Co.*  
 City or town. (If outside city or town limits, write RURAL and give nearest town)  
 Street No. (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

3. (a) FULL NAME *Elizabeth A. Burkins*  
 4. Sex *Female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *widowed*  
 6.(b) Name of husband or wife *Harry Burkins*  
 7. Birth date of deceased (mo., day, yr.) *Jan 10-1888*  
 8. AGE: Years *60* Months *3* Days *7* If less than one day  
 hrs. *0* min. *0*  
 9. Birthplace *Conowingo, Md.* (Town, county, and state)  
 10. Usual occupation *Housewife*  
 11. Industry or business *Randolph Barron*  
 12. Name of Father *Randolph Barron*  
 13. Birthplace *Conowingo, Md.*  
 14. Maiden name *Rachel Hovershure*  
 15. Birthplace *Conowingo, Md.*  
 16. Informant *Charles Burkins*  
 Address *Rising Sun, Md.*  
 17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *April 20, 1948* (month) (day) (year)  
 Cemetery or crematory *Burial*  
 Location *Rising Sun, Md.*  
 18. Funeral director *J. E. Tyson*  
 Address *Rising Sun, Md.*  
 19. (Date record by registrar) *Apr 19 48* Registrar *J. E. Tyson*  
 Permit issued *4-19-48* Address *Rising Sun, Md.* Date signed *4/17/48*

3. (b) Social Security Number .....

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 17 1948* at *3304*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19*, and that I last saw her *alive* on *19*.

Immediate cause of death *Obstruction of bowels.*

Due to *.....*

Due to *.....*

Other conditions *.....*  
 (Include pregnancy within 3 months of death)

Major findings of operations *.....* Date of op. *.....*

Autopsy results *.....*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

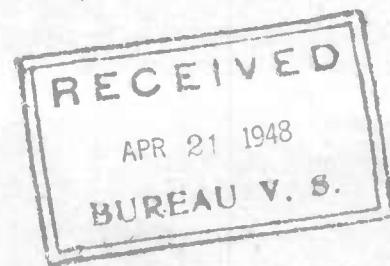
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of *.....*

Where did injury occur? (City or town) (County) (State) *.....*

Injured at home, farm, industry, public place (where?) *.....*

Means of injury *.....* Injured at work? *.....*

23. SIGNATURE *John D. Dodsden, M.D.*  
 for *Cecil County*  
 M. D. or other *.....*  
 Address *Young Sun, Md.* Date signed *4/17/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Supply every item of information carefully. Please write the causes of death clearly and legibly. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03761

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

## 1. PLACE OF DEATH

County

City or town

*Berwyn*  
*Rising Sun Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

*Apr 26 1948*

*4-26-48*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Rising Sun Rural* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*April 25 1948 at 8 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 1936 to April 25 1948*and that I last saw him alive on *April 24 1948*

Immediate cause of death

*artery occlusion**Pulmonary*

Due to

*(5/24/48-05)*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*P. H. Doolan, M.D.* M. D. or otherAddress *Rising Sun, Md.* Date signed *Apr 26 1948*

RECEIVED

APR 27 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

03762

## CERTIFICATE OF DEATH

Reg. Dist. No.

90

## 1. PLACE OF DEATH:

County.....

Cecil  
Earleville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

72 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Sophia Duttairell

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Henry Sutton Duttairell

7. Birth date of deceased (mo., day, yr.)

July 1 - 1855

6. (c) If alive, give age..... years

8. AGE:

92

Years

9

Months

18

Days

18

If less than one day

hrs.

min.

9. Birthplace.....

Foxboro - Mass.

(Town, county, and state)

10. Usual occupation.....

House

11. Industry or business

Obediah Sherman

MOTHER

FATHER

12. Name.....

Foxboro - Mass.

13. Birthplace

MOTHER

Julia Cooke

FATHER

Worcester, Mass.

14. Maiden name.....

MOTHER

Ethel Duttairell Beller

FATHER

Earleville - Md.

15. Birthplace

MOTHER

Burial

FATHER

Date thereof. April 22, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

16. Informant.....

Address

17. Funeral director.....

Address

18. Funeral director.....

Address

19. Date rec'd by registrar.....

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Cecil

City or town.....

Earleville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

✓

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 19, 1948, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18, 1948, to April 19, 1948,

and that I last saw her alive on April 18, 1948.

Immediate cause of death.....

Cerebral Sclerosis  
after 4 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

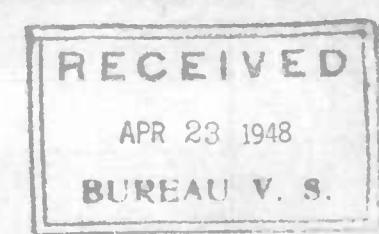
Dorsey W. Lewis

M. D. or other

Address.....

Middletown - Del.

Date signed 4/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03763

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

1 day

## 3. (a) FULL NAME

Matilda Finberg

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Vaino Finberg

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.)

Sept 1-1895

8. AGE:

Years 52

Months 7

Days 11

It less than one day hrs. min.

9. Birthplace

Sippola, Usp. L. Finland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Esa Tapolu

13. Birthplace

Finland

14. Maiden name

no information

15. Birthplace

16. Informant

Vaino Finberg

Address

North East, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 14 1948

(month) (day) (year)

Cemetery or crematory

Methodist Cemetery

Location

North East, Maryland

18. Funeral director

Joseph R. Grant

Address

North East, Maryland

19. April 13 1948

(Date rec'd by registrar)

F. R. Friesen

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

North East, Maryland

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946 to 11 April 1948

and that I last saw her alive on 11 April 1948

Immediate cause of death

Pulmonary edema

DURATION 24 hrs

Due to Chronic Rheumatic Endocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

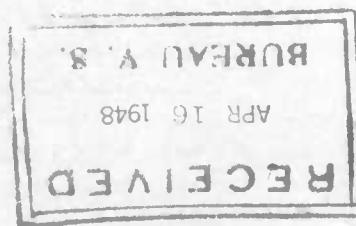
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Klaus H. Friesen, M.D.

M. D. or other

Address North East, Md Date signed 12 Apr 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03764

## CERTIFICATE OF DEATH

54a  
CB  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County... CecilCity or town... Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

VETERAN'S ADMINISTRATION HOSPITAL

How long in hospital or institution?... 21 hours

## 3. (a) FULL NAME

FLANIGAN, Jackson L.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife... Iva Casey Flanigan6. (c) If alive, give age... 43 years7. Birth date of deceased (mo., day, yr.) March 17, 19978. AGE: Years 51 Months 0 Days 24 If less than one day  
hrs. ..... min. ....9. Birthplace... Harrison County, West Virginia  
(Town, county, and state)10. Usual occupation... Glass Worker

## 11. Industry or business

MOTHER FATHER 12. Name... William Flanigan13. Birthplace Harrison County, West Virginia14. Maiden name... Tina Varner15. Birthplace Harrison County, West Virginia16. Informant... Iva Casey FlaniganAddress Salem, Route 2, West Virginia17. Removal... Date thereof... April 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Mt. Olive CemeteryLocation Route 3, Salem, West Virginia18. Funeral director Lee A. Patterson & SonAddress Perryville, Md19. April 11, 1948 Ira E. Dugay  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... West Virginia County... HarrisonCity or town... Salem, Route 2, Box 96

(If outside city or town limits, write RURAL and give nearest town)

Street No... None

(If rural, give LOCATION)

2.(a) If veteran, name war... World War #1

## 3. (b) Social Security Number

Unknown

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 10

19. 48 at 3:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9 19. 48 to April 10 19. 48

and that I last saw him alive on April 10 19. 48

Immediate cause of death... Respiratory failure

Post-operative

DURATION

Due to... Brain tumor

4 months plus

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Massive brain tumor, probably glioma, rt. cerebrum. Date of op. ....Autopsy results... Not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

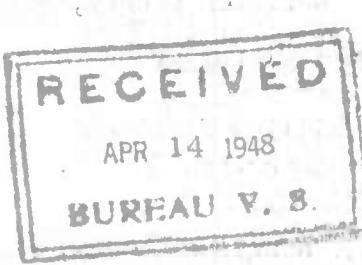
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... M. David Dugay, M.D. M. D. or otherAddress... VA HOSPITAL, PERRY POINT, Md. Date signed April 10, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03765

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

## 1. PLACE OF DEATH:

County.....

City or town.....

Elliot

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

16 hours.

Hospital, institution, or street address where death occurred:

Union Hospital Elliot

How long in hospital or institution?

16 hours.

## 3. (a) FULL NAME

Robert William Frazer.

## 3. (b) Social Security Number

4. Sex

M. Male Single

5. Color or race

6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 30 1947

6. (c) If alive, give age

years

8. AGE:

Years 6 Months 17 Days If less than one day hrs. min.

## 9. Birthplace

Wilmington Del.

(Town, county, and state)

## 10. Usual occupation

Childs Infir

## 11. Industry or business

George B Frazer.

## 12. Name

George B Frazer.

## 13. Birthplace

Childs Ind.

## 14. Maiden name

Mabel Gubl.

## 15. Birthplace

Kingsville Pa

## 16. Informant

George B. Frazer

## Address

Elliot Md. P.D.

## Burial

Burial

Date thereof apr 20 1948

(month) (day) (year)

## Cemetery or crematory

Sharpes Grd

## Location

Foothill Md

## 18. Funeral director

P. J. Jones

## Address

Private Dr

## 19. Date rec'd by registrar

April 19 1948

## Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. Cecil

City or town.....

Elliot Rural.

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

April 17 1948 at 4:30 P.M.

## 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19....., to..... 19.....

and that I last saw h. alive on..... 19.....

Immediate cause of death.....

Bilateral  
Pneumonia

Due to.....

Tendancy to  
mongolism

Other conditions.....

(Include pregnancy within 8 months of death)

## Major findings or operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

## Means of injury.....

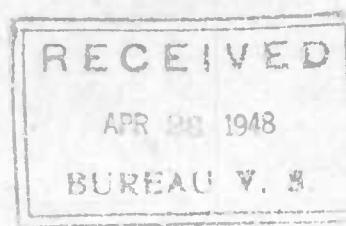
## Injured at work?

## 23. SIGNATURE

Medical Examiner  
for Cecil County

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

548

03766

96

## CERTIFICATE OF DEATH

Reg. Dlat. No.

## 1. PLACE OF DEATH:

County..... CecilCity or town..... Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 days

Hospital, Institution, or street address where death occurred:

..... VA Hospital, Perry Point, Md.How long in hospital or institution?..... Same as above

## 3. (a) FULL NAME

GILLIAM, William M. Gilliam

4. Sex

Male M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife.....

Unknown

7. Birth date of deceased (mo., day, yr.)

Nov. 8, 1897

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

50

4

24

hrs.

min.

9. Birthplace..... Georgia

(Town, county, and state)

10. Usual occupation.....

Unknown Painter

11. Industry or business

12. Name..... Mrs. J. H. Gilliam13. Birthplace..... Unknown14. Maiden name..... Unknown15. Birthplace..... Unknown16. Informant..... Hospital recordsAddress..... VA Hospital, Perry Point, Md.

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof..... 4-4-48

(month) (day) (year)

Cemetery or crematory.....

Unknown

Location..... Rome, Georgia

18. Funeral director.....

PENNINGTON & SONAddress..... Havre de Grace, Md.19. April 34 48 (Date rec'd by registrar)19. June 5, 1948 (Date of death)19. June 5, 1948 (Date of death)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince GeorgesCity or town..... Laurel (If outside city or town limits, write RURAL and give nearest town)Street No..... 429 Main Street (If rural, give LOCATION)2.(a) If veteran, name war..... WW-II

## 3. (b) Social Security Number

Unknown

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2, 1948 at 5:45AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1948 to April 2, 1948and that I last saw h. in alive on April 2, 1948

Immediate cause of death.....

Malignant tumor of the brain, frontal lobe.

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... R. C. DODSON, M.D. Medical Examinerfor Cecil County

M. D. or other

R. C. DODSON, Coroner, Cecil Co. 4-2-48

Address..... Rising Sun, Md. Date signed.....

RECEIVED

APR 6 1948

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, ~~WE~~ UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

03767

96

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County..... **Cecil**City or town..... **Port Deposit, Rural**  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... **34 Years**

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

**Anna Giorgio**4. Sex **Female** 5. Color or race **Italian** 6. (a) Single, married, widowed, or divorced **Married**6. (b) Name of husband or wife..... **Francisco Giorgio**7. Birth date of deceased (mo., day, yr.) **March ? 1879** 6. (c) If alive, give age..... years8. AGE: Years **69** Months  Days  If less than one day  hrs.  min. 9. Birthplace..... **Italy**  
(Town, county, and state)10. Usual occupation..... **House Wife**

## 11. Industry or business

12. Name..... **Matthew De Nardo**13. Birthplace..... **Italy**14. Maiden name..... **Antoinetta Pecia**15. Birthplace..... **Italy**16. Informant..... **Francisco Giorgio**Address..... **Port Deposit, Md. Rural**17. Burial..... **Burial** Date thereof..... **April 28, 1948**  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **Brookview Cemetery**Location..... **Rising Sun, Md. Rural**18. Funeral director..... **K.W. Patterson & Son**Address..... **Perryville, Md.**19. Date rec'd by registrar..... **April 28, 1948** **Irene E. Daugherty**  
Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Cecil**City or town..... **Port Deposit, Rural**  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 24, 1948** **8P.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan. 20, 1948** to **Apr. 24, 1948** and that I last saw her **alive** on **April 24, 1948**

Immediate cause of death.....

**Chronic myocarditis**  
**Chronic Endocarditis.**

DURATION

**8 yrs**  
**8 yrs.**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

**B. A. Benson, M.D.**  
M. D. or other  
Address..... **Port Deposit, Md.** Date signed **4/27/48.**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03768

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:  
County..... *Ellicott*  
City or town..... *Ellicott* (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *19 hours.*  
Hospital, institution, or street address where death occurred  
City or town..... *Ellicott Hospital* (If outside city or town limits, write RURAL and give nearest town)  
How long in hospital or institution? *19 hours.*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... *Del.* County..... *Wilmington*  
City or town..... *Wilmington* (If outside city or town limits, write RURAL and give nearest town)  
Street No. ....

3. (a) FULL NAME *Ronald D Hanna*

4. Sex *M* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Feb 21 1948* 8. (c) If alive, give age..... years

8. AGE: Years *1* Months *12* Days *12* If less than one day  
hrs. ..... min. ....

9. Birthplace..... *McClintock Creek*  
(Town, county, and state) *Ellicott*

10. Usual occupation..... *Clerk*

11. Industry or business..... *Applaud Hanna Jr.*

MOTHER FATHER  
12. Name..... *Ronald Hanna Jr.*  
13. Birthplace *Langley Co. Va.*

MOTHER  
14. Maiden name *Gladys Roark*  
15. Birthplace *Asli, N.C.*

16. Informant *Ellicott Hospital record*  
Address *Ellicott Md.*

17. Burial..... *Burial* Date thereof *Apr 15-48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Glasgow Cemetery*  
Location *Glasgow Maryland*

18. Funeral director *Huppins*  
Address *Ellicott, Md.*

19. April 13 1948 (Date rec'd by registrar) *J. R. Fraser* (Signature)  
Registrar

2. (a) If veteran, name war.....

3. (b) Social Security Number

4. MEDICAL CERTIFICATION

20. DATE OF DEATH *April 12 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19*  
and that I last saw him ..... alive on *19*

Immediate cause of death *Pygocelitis*  
Due to *Pygocelitis*  
Due to *Pygocelitis*  
Other conditions.....

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Moans of injury ..... Injured at work? ..... *Medical Examiner*  
*Police Department* *Delaware County*

23. SIGNATURE *John S. Smith* M. D. or other  
Address *Ellicott, Md.* Date signed *Apr 12-48*

RECEIVED

APR 14 1948

BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03769

## CERTIFICATE OF DEATH

552

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Cecil  
 County: Elkton  
 City or town: Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs  
 Hospital, Institution, or street address where death occurred: 136 E High St  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: maryland County: Cecil  
 City or town: Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 136 E High  
 (If rural, give LOCATION)

3. (a) FULL NAME Maurice Edgar Hudson

3. (b) Social Security Number

4. Sex: Male 5. Color or race: white 6. (a) Single, married, widowed, or divorced: Married  
Elsie Hudson  
 8. (b) Name of husband or wife: Elsie Hudson  
 7. Birth date of deceased (mo., day, yr.): Sept 21 1895 8. (c) If alive, give age: years  
 8. AGE: 52 Years Montha Days If less than one day  
hrs. min.

9. Birthplace: maryland  
 (Town, county, and state)

10. Usual occupation: Game Warden

11. Industry or business: Game Warden

12. Name: Joshua Hudson  
 MOTHER FATHER: maryland

13. Birthplace: maryland

14. Maiden name: Maggie Beckworth

15. Birthplace: maryland

16. Informant: Mrs Elsie Hudson

Address: 136 E High St Elkton Md

17. Burial: Burial Date thereof: Apr 6 1948  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory: Bethel Cemetery

Location: Chesapeake City Md Rd

18. Funeral director: H W Pippin

Address: Elkton Md

19. Date rec'd by registrar: April 6 1948 Registrar: F R Fraser  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1948 a. 45 p.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to April 3 1948  
 and that I last saw h. in alive on April 3 1948  
 Immediate cause of death: Carcinoma of the rectum  
left, with intestinal obstruction  
gastroenteritis melasma  
 Due to: 1 year

Due to: \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings or operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

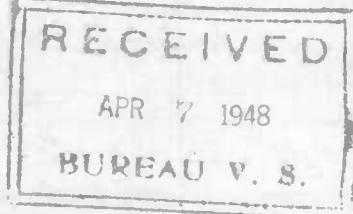
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: S Ralph Hudson Jr., M.D. M.D. or other \_\_\_\_\_

Address: Elkton, Maryland Date signed: Apr 5 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

Reg. Dist. No. 92

03770

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: <u>Cecil</u>	
County.....	
City or town..... <u>Elkton</u> Md (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? <u>75 yrs.</u>	
Hospital, Institution, or street address where death occurred: <u>W Main St.</u>	
How long in hospital or institution?	
3. (a) FULL NAME <u>Malvone T. Jeffers</u>	
4. Sex <u>Male</u>	5. Color or race <u>W.H.</u>
6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Josephine T. Jeffers</u>	
7. Birth date of deceased (mo., day, yr.) <u>January 18, 1873</u>	
8. AGE: Years <u>75</u> Months <u>3</u> Days <u>22</u> If less than one day hrs. ..... min. ....	
9. Birthplace <u>Elkton</u> Md (Town, county, and state)	
10. Usual occupation <u>Petd Boat Builder</u>	
11. Industry or business	
12. Father Name <u>Hermann Jeffers</u>	
13. Birthplace <u>Elkton</u> Md	
14. Maiden name <u>Jennie Cantwell</u>	
15. Birthplace <u>Elkton</u> Md	
16. Informant <u>Mrs Josephine T. Jeffers</u>	
Address <u>W. Main St Elkton Md.</u>	
17. Burial <u>Burial</u> Date thereof <u>Apr 12 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)	
Cemetery or crematory <u>Elkton</u>	
Location <u>Elkton</u> Md	
18. Funeral director <u>H. W. Hupp</u>	
Address <u>Elkton</u> Md	
19. (Date rec'd by registrar) <u>April 12 1948</u> <u>J. R. Fraser</u> Registrar	

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Cecil  
City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. W. Main St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 a. 9 A.M.  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 30 to Apr 9 1948  
and that I last saw him alive on April 9 1948

Immediate cause of death

Acute Cardiac dilatation

Due to Cardiac renal vascular  
disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE Dr. Bates, M.D.

M. D. or other

Address Elkton Md Date signed 4/9/48

RECEIVED  
APR 14 1948  
BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03771

M

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....

City or town.....

Cecil  
Clouds

14 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elijah Lyle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Eve married Sarah Lyle

6. (b) Name of husband or wife

6. (c) If alive, give age 34 years

7. Birth date of  
deceased (mo., day, yr.)

April 4 1902

8. AGE:

Years 65 Months 11 Days 1 If less than one day  
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Track Foreman

11. Industry or business

Meetie Lyle

MOTHER FATHER

12. Name

Farmville Va.

13. Birthplace

Dally Henderson

14. Maiden name

Farmville Va.

15. Birthplace

Robert Lyle

16. Informant

Elkton Md.

Address

Removal

Date thereof 4-4-48  
(month) (day) (year)

17. Cemetery or crematory

Keyesville Va.

Location

Keyesville Va.

18. Funeral director

Edw. R. S. Bell

Address

909 Poplar St. Wil. Del.

19. Date rec'd by registrar

April 2 1948

(Date rec'd by registrar)

F. R. Fraser

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Md. Cecil

County.....

Clouds

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

705-09-7329

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 1

1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death

Acute coronary  
disease.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

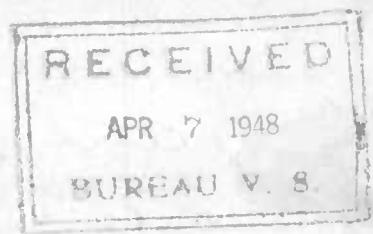
23. SIGNATURE

Medical Examiner

Cecil County

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03772

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Elkton Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? -

## 3. (a) FULL NAME

Charles T. McCauley4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife... Katherine Long McCauley6. (c) If alive, give age... - years

7. Birth date of deceased (mo., day, yr.)

January 28 18618. AGE: 87 Years 2 Months 10 Days If less than one day hrs. 0 min.9. Birthplace... Elkton, Rural, Cecil Co, Md  
(Town, county, and state)10. Usual occupation... Farmer

## 11. Industry or business

Retired12. Name... James T. McCauley13. Birthplace... Maryland14. Maiden name... Eliya Biddle15. Birthplace... Maryland16. Informant... C. Otis McCauleyAddress... North East Rd17. Burial... Burial Date thereof... 4-10-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... MethodistLocation... Cherry Hill, Maryland18. Funeral director... People P. FuneralAddress... North East Rd19. (Date rec'd by registrar) April 9 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... CecilCity or town... Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. -

(If rural, give LOCATION)

2.(a) If veteran, name war... not a veteran

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 114

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930 to April 7 1948  
 and that I last saw him alive on April 6 1948Immediate cause of death Cerebral hemorrhageDue to arterio sclerosis, general

Due to...

Other conditions gangrene of foot

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Heberle Bates Jr. M.D.

M. D. or other

Address... Elkton, Md Date signed 4/9/48

RECEIVED

APR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03773

96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... CECIL

City or town..... PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

1 month 21 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution?

Same as above

## 3. (a) FULL NAME

THOMAS MC COY

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

Negro

Married

## 6. (b) Name of husband or wife

Unknown

## 7. Birth date of deceased (mo., day, yr.)

February 5, 1885

## 6. (c) If alive, give age .....

years

## 8. AGE:

Years

Months

Days

If less than one day

63

2

10

.....hrs. ....min.

## 9. Birthplace.....

Hyacinth, Va.

(Town, county, and state)

## 10. Usual occupation.....

Unemployed

## 11. Industry or business

FATHER

## 12. Name.....

Unknown

MOTHER

## 13. Birthplace.....

Unknown

MOTHER

## 14. Maiden name.....

Unknown

MOTHER

## 15. Birthplace.....

Unknown

## 16. Informant.....

Hospital Records

Address

VAH, Perry Point, Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

4-16-48

(month) (day) (year)

Cemetery or crematory.....

Baltimore National Cemetery

Location

Baltimore, Maryland

18. Funeral director.....

THOMAS E. KELSON

Address

1303 Presstman Ave., Baltimore, Md.

19. April 16

19. 48

(Date rec'd by registrar)

Irene E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Independent City

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1818 Lorman Street

(If rural, give LOCATION)

WW-I

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

216-08-8195

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 15th

1948

12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 24th

1948

to April 15th 1948

and that I last saw him alive on April 15th 1948

Immediate cause of death.....

Cerebral hemorrhage

DURATION

5 min.

Due to..... Syphilitic heart disease

1 year

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

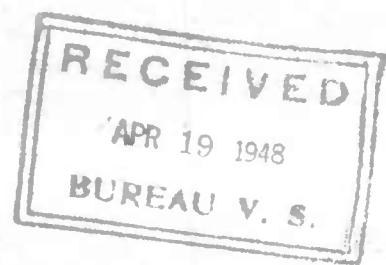
23. SIGNATURE: A. E. TROLLINGER, M.D., Chf. Prof. Services

M. D. or other

VAH, Perry Point, Md.

4-16-48

Address..... Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03774

## CERTIFICATE OF DEATH

Reg. Date. No. 92

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Eaton

3 hours.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital Elkhorn

How long in hospital or institution?

3 hours.

## 3. (a) FULL NAME

Robert Lee Michael

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

Wife Widowed

6. (b) Name of husband or wife

Florence Michael

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 10 1879

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

68

8

2

hrs. min.

9. Birthplace

Harford Co. Md.

(town, county, and state)

10. Usual occupation

Engineer/80.

11. Industry or business

MOTHER FATHER

James Michael

12. Name

Harford Co. Md.

13. Birthplace

Emily Cox

14. Maiden name

Harford Co. Md.

15. Birthplace

Miss Diversely v. Michael

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

for Cecil County

M. D. or other

Date signed

Address

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M MARGIN RESERVED FOR BINDING I

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1741

Montpelier St.

(If rural, give LOCATION)

✓

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12 1948 at 6709

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19...

to

19...

and that I last saw h... alive on

Immediate cause of death

Acute Coronary Disease

DURATION

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

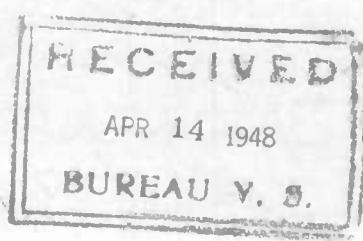
for Cecil County

M. D. or other

Date signed

Address

VS-A15 4/12-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

03775

157d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 days

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Patricia Ann Kneis

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

S.

## 6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Apr. 26, 1948

## 8. AGE:

Years

Months

Days

If less than one day

2 hrs. min.

## 9. Birthplace.....

(Town, county, and state)

## 10. Usual occupation.....

## 11. Industry or business.....

## MOTHER FATHER

12. Name.....

James F. Kneis

Blair, Md.

Pa.

13. Birthplace.....

Marietta

Cathouse

Md.

14. Maiden name.....

Marietta

Cathouse

Md.

15. Birthplace.....

Marietta

Cathouse

Md.

16. Informant.....

James F. Kneis

Blair, Md.

Pa.

17. Burial.....

Burial

Cemetery or crematory.....

Cemetery

or

crematory

Location.....

Foot

Baylor

Md.

Rural

Area

Cathouse

Md.

18. Funeral director.....

George

A. Patterson

&amp; Son

Cathouse

Md.

19. Address.....

772

Hollingsworth

Elkton

Md.

20. Date rec'd by registrar.....

April

27

1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

## 2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

20 April

1948, at 2:30 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 April

1948

to

26 April

1948

and that I last saw her alive on

26 April

1948

## Immediate cause of death.....

Pneumonitis

## Due to.....

Intravascular Hemolysis

## DURATION

2 days

2 days

## Due to.....

## Other conditions.....

(Include pregnancy within 8 months of death)

## Major findings or operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

## Means of injury.....

Injured at work?

## 23. SIGNATURE.....

George J. Kneis, Jr.

M. D. or other

## Address.....

Elkton, Md.

Date signed 27 April 48

RECEIVED

APR 29 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. is especially important. Physicians: please write the causes of death clearly and legibly.

03776

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

486

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH: *Cecil Chesapeake City, Md.*  
County.....  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*F. W. M. Merged.*

6. (b) Name of husband or wife

*Wells T. Prinsen*

7. Birth date of deceased (mo., day, yr.)

*May. 25 1903*

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

*44 10 13* hrs. min.

9. Birthplace

*Chesapeake City, Md.*  
(Town, county, and state)

10. Usual occupation

*at home.*

11. Industry or business

FATHER

*George Carter*

12. Name

MOTHER

*Chesapeake City, Md.*

13. Birthplace

14. Maiden name

*No. Inf.*

15. Birthplace

16. Informant

*Wells T. Prinsen*

Address

*Chesapeake City, Md.*

17. Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

*Bethel Am. Ch. C. C.*

Location

*Chesapeake City, Md.*

18. Funeral director

*Alb. Kippin*

Address

*Elkton, Md.*

19. Date rec'd by Registrar

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For no born infants give residence of mother)

State

*Md.* County *Cecil*

City or town

*Chesapeake City*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

*Md.*  
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

*April 7 1948* at 30 A.M.*April 7 1948* to *April 7 1948*and that I last saw her alive on *April 6 1948*

Immediate cause of death

*Carcinoma of uterus*

DURATION

*1 year*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

*Carcinoma of body of uterus*

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

*Henry Doss M.D.*

M. D. or other

Address

*Chesapeake City, Md.*

Date signed

4/7/48

RECEIVED

APR 12 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03777

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

## 1. PLACE OF DEATH

County

City or town

*Civil*  
*North East Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Thompson Ramsey Reed*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M.* *White Widower*

6. (b) Name of husband or wife

*Julia E Reed.*7. Birth date of deceased (mo., day, yr.) *May 7 1866*

6. (c) If alive, give age years

8. AGE: 

Years	Months	Days	If less than one day
81	11	18	hrs. min.

9. Birthplace *North East Md.*

(Town, county, and state)

10. Usual occupation. *Retired Farmer.*

## 11. Industry or business

MOTHER FATHER *William Reed*  
12. Name *William Reed*

13. Birthplace *North East Md.*  
14. Maiden name *Margaret Ferguson*

15. Birthplace *North East Md.*  
16. Informant *Chester Reed.*

Address *North East Rd Md.*  
17. Burial *Burial* Date thereof *Apr 28-48*

Cemetery or crematory *Methodist* Date thereof *Apr 28-48*  
(Burial, cremation, or removal. Which?)

Location *Baptist Union Rd*

18. Funeral director *Joseph O' Shaugh*

Address *North East Md.*

19. 4-28 1948 *Leda J. Powers*  
(Date rec'd by registrar) *per M.B.M.* Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Civil*City or town *North East Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

*none*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 25 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death

*Acute coronary*  
*cardiac*  
*anticoagulants*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURES

Cecil County  
M. D. or otherAddress *Bladodson L. H. Ramsey* Date signed *4/25/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and legible.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03778

## CERTIFICATE OF DEATH

131a  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Charles M. Reisler

7. Birth date of

deceased (mo., day, yr.)

Sept 24 1860

6. (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 87 Month 6 Days 22 If less than one day

hrs. min.

8. AGE: Years 87 Month 6 Days 22 If less than one day

hrs. min.

9. Birthplace: near Rising Sun, Cecil Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

12. Name: Joseph Stephens

13. Birthplace: Pennsylvania

14. Maiden name: Philena Lee

15. Birthplace: Pennsylvania

16. Informant: John Reisler

Address: Nottingham P. O. Pa

17. Burial: Date thereof: 4-19-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Rosebank

Location: Calverton, Md.

18. Funeral director: Joseph R. Grant

Address: North East, Md.

19. (Date issued by registrar) Apr 19 48

Registrar: 2200 Washington

Date signed: 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 15 1948 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to April 15 1948 and that I last saw her alive on April 15 1948.

Immediate cause of death: nephritis

Cereosclerosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

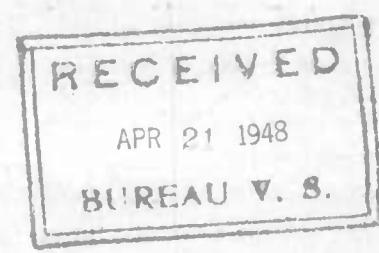
Means of injury: Injured at work?

23. SIGNATURE:

M. D. or other

Address: Oxford, Penna.

Date signed: 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03779

## CERTIFICATE OF DEATH

1310  
Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County

Baltimore

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 days

Hospital, institution, or street address, where death occurred:

Union Hosp.

How long in hospital or institution?

13 days

## 3. (a) FULL NAME

Lewis Edward Roseberry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

married

6. (b) Name of husband or wife

Sophie Roseberry

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 4-1894

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Tibre Mill

MOTHER FATHER

Andrew E. Roseberry

13. Birthplace

Pulaski Virginia

14. Maiden name

Agnes Clegg

15. Birthplace

Dro Record

16. Informant

Mrs. Sophia H. Roseberry

Address

Elkton Md P. D. 3

17. Burial

Date thereof apr 7 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Newark Del

Location

Newark Del

18. Funeral director

P. T. Jones

Address

Newark Delaware

April 7 1948

F. R. Frazer

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Elkton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Elkton Md P. D. 3

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 4<sup>th</sup> 1948 at 11:45<sup>a</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 27 1948 to April 4<sup>th</sup> 1948and that I last saw him alive on April 4<sup>th</sup> 1948

Immediate cause of death

Cardio-vascular-renal  
disease - hypertension

Due to type

DURATION

Unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

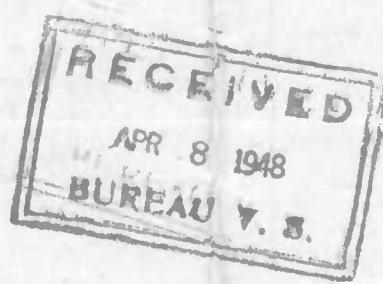
J. H. M. Knight M.D.

M. D. or other

Address

Elkton Md

Date signed 4/4/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03780

## CERTIFICATE OF DEATH

121  
Reg. Date. No. 92

## 1. PLACE OF DEATH:

County

City or town

Cecil  
Eaton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 3 days

## 3. (a) FULL NAME

Mary J. Simeone

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

J. Summerfield Simeone

7. Birth date of deceased (mo., day, yr.) January 3-1857

8. AGE: Years 91 Months 3 Days 8 If less than one day hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name William Jones

13. Birthplace Delaware

14. Maiden name Mary Foxwell

15. Birthplace Delaware

16. Informant Miss Hilda Moffit

Address North East, Maryland

17. Burial Date thereof April 14 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location North East, Maryland

18. Funeral director Joseph R. Grant

Address North East, Maryland

19. Date rec'd by registrar April 13 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Cecil

City or town North East (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1948 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1948 to 11 April 1948

and that I last saw h.c. alive on 11 April 1948

Immediate cause of death

Peritonitis

Due to Acute suppurative appendicitis

DURATION  
3 days

4 days

Due to

Other conditions Arteriosclerotic Cardio-  
vascular disease

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Klaus H. Haertel M.D.

M. D. or other

Address North East, Md Date signed 12 April 48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159

Reg. Dist. No. 037892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

## 1. PLACE OF DEATH:

County

Cecil

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution?

## 3. (a) FULL NAME

Bry. Bry. Stob

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

April 28, 1948

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day  
0 hrs. 35 min.

## 9. Birthplace

Elkton Md

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

MOTHER FATHER

Taylor Stob

Willa Mae Cauley

13. Birthplace

Md

14. Maiden name

15. Birthplace

## 16. Informant

Hosp. Record

Address

Eckert Md.

## 17. Burial

Date thereof..... 5-3-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bethel May 3 1948

Location

Chesapeake City Md RD

## 18. Funeral director

H. C. Pippin

Address

Elkton Md

## 19. Date rec'd by registrar

May 3 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Cecil

City or town (If outside city or town limits, write RURAL and give nearest town)

Chesapeake City

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

4/28 48 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 1948, for 4/28 48

and that I last saw h. m. alive on 4/28 48

Immediate cause of death

Premature foetus 6 mos

Due to

concern

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

none

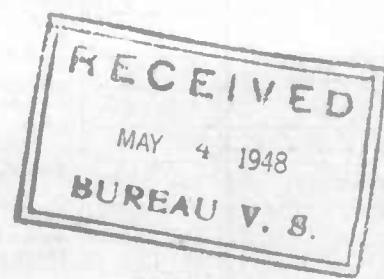
Injured at work?

## 23. SIGNATURE

H. C. Pippin

M. D. or other

Address Chesapeake City Md Date signed 5/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03782

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

96

## 1. PLACE OF DEATH:

County..... CecilCity or town..... Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 11 mos. 14 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? 6 yrs. 6 mos. 18 days

## 3. (a) FULL NAME

TURNER, Charles T.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec. 23, 1874

8. AGE:

Years

Months

Days

If less than one day

73

4

6

hrs.

min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Unknown

11. Industry or business

Unknown - deceased

FATHER

MOTHER

MOTHER

FATHER

UnknownUnknown

13. Name.....

14. Maiden name.....

15. Birthplace.....

Unknown - deceasedUnknownUnknown - deceasedUnknown16. Informant..... Hospital Records

Address

17. Removal.....

Date thereof..... May 4, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Baltimore National CemeteryLocation..... Baltimore, Md.

18. Funeral director

PENNINGTON & SON  
Address Havre de Grace, Md.

19. Date record by registrar

May 4, 1948

(Date record by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... BaltimoreCity or town..... Lansdowne P.O. (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish-American ✓

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29, 19. 48 at 6:52 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 19. 42 to Apr. 29, 19. 48and that I last saw h. m. alive on April 29, 19. 48

Immediate cause of death

Pneumonia, bronchial, left

DURATION

72 hrs.Due to Tuberculosis, pulmonary, bilateral,  
al, far advancedUnknown

Due to

Other conditions Arteriosclerosis, generalized,  
moderateUnknown

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. -- Date of

Where did injury occur? (City or town) (County) (State)

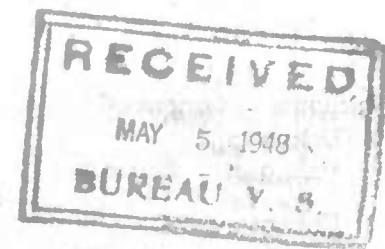
Injured at home, farm, industry, public place (where?)

Means of injury --

Injured at work?

23. SIGNATURE

H. NAGLER, M.D. Professional Services M.D. or other  
Address VAH, Perry Point, Md. Date signed 5-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03783

83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... CECIL

City or town..... PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

10 yrs. 7 mos. 21 das.

How long in above place of death?

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution?

Same as above

## 3. (a) FULL NAME

THOMAS TWILLEY

## 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Negro Divorced

6.(b) Name of husband or wife Mrs. Hattie Twilley

7. Birth date of deceased (mo., day, yr.) April 1, 1893

6.(c) If alive, give age - years

8. AGE: Years Months Days If less than one day

55 0 22 hrs. min.

9. Birthplace..... Salisbury, Maryland

(Town, county, and state)

10. Usual occupation..... Unknown

11. Industry or business

FATHER 12. Name..... Unknown

13. Birthplace..... Unknown

MOTHER 14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hospital Records

Address VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-26-48

(month) (day) (year)

Cemetery or crematory..... Unknown

Location..... Salisbury, Maryland

18. Funeral director..... Cunningham &amp; Son

Address Havre de Grace, Maryland

19. April 26 1948 Jane E. Daugherty

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico

City or town..... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 115 Rose Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 23rd 1948, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1937, to April 23, 1948,

and that I last saw h. 1m. alive on April 23rd 1948.

Immediate cause of death

Subdural hemorrhage, right

DURATION

7 days

Due to General paralysis, cerebral type

Unknown

Due to

Other conditions Broncho-pneumonia, right

6 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. E. TROLLINGER, M.D., Chief, Prof. Serv.

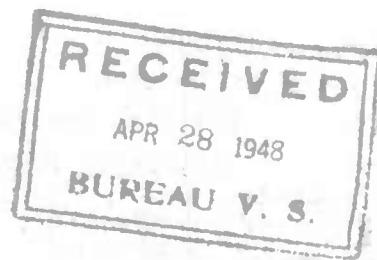
M. D. or other

VAH, Perry Point, Md.

4-26-48

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03784

1246 CR Reg. Dist. No. 96

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County CECIL

City or town PERRY POINT, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years 13 days

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution? Same as above

## 3. (a) FULL NAME

Frederick L. Walker

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male

White

Married

## 6.(b) Name of husband or wife

Harriet S. Walker

## 7. Birth date of deceased (mo., day, yr.)

July 27, 1893

## 6.(c) If alive, give age — years

## 8. AGE:

Years

Months

Days

If less than one day

54

8

17

hrs.

min.

## 9. Birthplace

Georgia

(Town, county, and state)

## 10. Usual occupation

Canteen Manager

## 11. Industry or business

## MOTHER FATHER

H. L. Walker

Unknown

Unknown

Unknown

Unknown

## 16. Informant

Hospital Records

Address

VAH, Perry Point, Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 4-14-48

(month) (day) (year)

Cemetery or crematory

Unknown

Location

Atlanta (Decatur), Georgia

Pennington Cem

## 18. Funeral director

Address Havre de Grace, Md.

19. Date record by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Georgia County DeKalb

City or town Decatur (If outside city or town limits, write RURAL and give nearest town)

Street No. 118 Champlain Avenue (If rural, give LOCATION)

2.(a) If veteran, name war WW-I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1943 to April 14th 1948

and that I last saw him alive on April 14th 1948

## Immediate cause of death

Hemorrhage, massive, gastric

Due to Esophageal varices

## DURATION

48 hours

Unknown

Due to Cirrhosis of the liver

Unknown

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

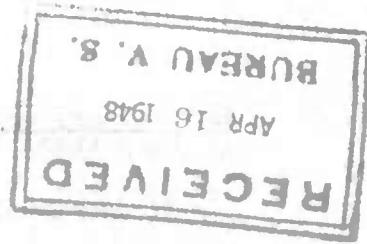
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE A. E. TROLLINGER, M.D., Chf. Prof. Services M. D. or other

Address VAH, Perry Point, Md. Date signed 4-14-48

Registrar



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

03785

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

Cecil

Rural near Elketon,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

R.D.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Margaret Elizabeth Walters

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. Wh Married.

6. (b) Name of husband or wife.....

William Walters

7. Birth date of

deceased (mo., day, yr.)

June 13, 1871

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

16 10 13 hrs. mtn.

9. Birthplace.....

Elkton, Cecil Co. Md.

(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

12. Name.....

Luka Goodyear

13. Birthplace.....

Elkton, Md.

14. Maiden name.....

Margret Woodside

15. Birthplace.....

Elkton, Md

16. Informant.....

William Walters

Address

Elkton, Md. Sengerly Rd.

17. Burial.....

Date thereof..... Apr. 29 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Cherry Hill

Location.....

Cherry Hill, Md

18. Funeral director.....

Hartmann

Address

Elkton, Md

19. Date rec'd by registrar.....

April 28 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Cecil

City or town.....

Rural near Elkton,

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Sengerly Rd.

(Rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 26 April 1948 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 April 1948 to 26 April 1948

and that I last saw her alive on 26 April 1948

Immediate cause of death.....

Cardiac Failure

DURATION

4 days

Due to..... Senility

Due to..... Cardio Renal Disease

Unknown

Other conditions..... Partial obstruction

Possible Pulmonary T.B.C.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

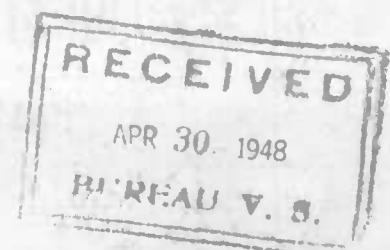
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

George J. Kreis, Jr., M.D. M.D. or other

Address..... Elkton, Md. Date signed..... April 29 1948



## Evidence for change of spell MARYLAND STATE DEPARTMENT OF HEALTH

of first name shown on:

2411 N. Charles St., Baltimore

1784

03786

ADM No. G 116 AUG 11 1948

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

Cecil

County

Elkton Rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

working on road

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Marlin  
Mervin E Wilhelm

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.) May 9 19098. AGE: Years 38 Months 11 Days 2 It less than one day  
hrs. min.9. Birthplace Baltimore Co. Md.  
(Town, county, and state)

10. Usual occupation Handy Man

## 11. Industry or business

12. Name Phillip H. Wilhelm

13. Birthplace Balto. Co. Md.

14. Maiden name Mary G. Diffenderfer

15. Birthplace Balto. Co. Md.

16. Informant Phillip Russell Wilhelm

Address 35 S. Fulton Ave. Balto. Md.

17. Removal Date thereof Apr. 13/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location New Baltimore, Md

18. Funeral director Whippin

Address Elkton, Md

19. April 13 1948

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

State Baltimore

County Freeland

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

World War 2

## 3. (b) Social Security Number

216-07-5573

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on

Immediate cause of death

Carbon Monoxide Poisoning.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results yes. CarB. Monoxide Poison

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-11-48

Where did injury occur Elkton Cecil Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Cabin

Means of injury gas heater Injured at work? no

23. SIGNATURE D. B. D. for Cecil Co. M. D. or other

Address Rising Sun, Md. Date signed 4-13-48

RECEIVED  
APR 14 1948  
BUREAU V. S.



